Valley Hi
Nursing & Rehabilitation

RESIDENT APPLICATION

**** PLEASE COMPLETE PRIOR TO ADMISSION****

Resident Name: _____

1. Resident admitted to Valley Hi from? _____

2. Please list all hospital stays **during the past 90 days**:

   Date Admitted _____ Hospital Name _____

   Date Discharged _____

   Date Admitted _____ Hospital Name _____

   Date Discharged _____

   Date Admitted _____ Hospital Name _____

   Date Discharged _____

3. Please list all skilled nursing facility stays **during the past 90 days**:

   Date Admitted _____ SNF Name _____

   Date Discharged _____

   Date Admitted _____ SNF Name _____

   Date Discharged _____

4. Does resident have a primary or supplemental insurance HMO plan? If yes, we must have a copy of the insurance card in order to contact the HMO plan **prior to** admission.

   Yes No

   Signature_____ Date_____

VALLEY HI NURSING & REHABILITATION

Name Last, First, Middle Initial	Admitted From	Resident Address (Street, City, State, Zip Code, County)	Phone Number

Social Security Number	Birth Date	Age	Birthplace (City/State/County)	Religion	Language	Sex	Marital Status

US Veteran/Branch	Citizen	Race	Medicaid ID Number	Medicaid Case Number

Medicare Number	Medicare Rx (Part D)/Other Pharmacy	Supplemental Insurance Name/Number

Primary Care Physician/Phone Number	Dentist/Phone Number	Eye Doctor/Phone Number

Funeral Home	Church

Power of Attorney/Guardian – Healthcare	Power of Attorney/Guardian – Property (Financial)

Notify in case of Emergency #1 Name/Address	Home Phone Number: Work Number: Cell/Pager Number:	Relationship

Notify in case of Emergency #2 Name/Address	Home Phone Number: Work Number: Cell/Pager Number:	Relationship

Notify in case of Emergency #3 Name/Address	Home Phone Number: Work Number: Cell/Pager Number:	Relationship

Consulting Physicians: (Cardiologist, Orthodedics, Psychiatrist, Neurologist, Nephrologist, Dermatologist, etc.)

Name	Specialty	Phone Number

Medical History	Month & Year	Hospital/Skilled Nursing Facility	Physician	Type of Treatment
Current Illnesses				
Past Illnesses				
Surgeries				
Fractures				
Falls				
Seizures or Convulsions				
Psychiatric				
Alcohol or Drug Abuse				
Infectious Diseases (MRSA, VRE, HIV, AIDS, TB, Hepatitis, C. diff)				
Other				

Description: Height_____ Weight_____

Describe use of: Alcohol_____ Tobacco_____

Describe sleep habits: ____ Normal ____ Requires sleeping pills ____ Noisy at night ____ Naps during day

____ Wanders at night ____ Awakens during night ____ Restless

Special Diet: _____

Drug Allergies: (Include any sensitivities or side effects experienced).

_____

_____

Food Allergies: _____

_____

Present Condition: (Check all that apply)

Ambulation
__ Independent
__Wheelchair
__Cane/Walker
__Bedridden
__Assistance Required
__One Person
__Two Person
__Electric Wheelchair

Impairment
__Vision
__Hearing
__Speech
__Incontinence
__Contractures
__Paralysis

Special Precautions
__Combative
__Chokes Easily
__Hides Pills
__Suicidal
__Wanders/Exit Seeking

Applicant Has
__Dentures
__Eyeglasses
__Hearing Aid
__Prosthesis
__Braces/Splints

Mental Status/Temperament
__Sociable
__Timid
__Independent
__Prefers being alone
__Prefers groups
__Mentally alert
__Confused
__Grouchy
__Suspicious
__Withdrawn
__Depressed
__Forgetful
__Cries easily
__Hallucinates
__Anxious
__Physically aggressive
__Other_____

Self-care Capability	Independent	Needs Assistance	Unable	Resistive	Combative
Washing face and hands					
Bathing/Showering					
Getting in and out of bed					
Caring for hair					
Caring for fingernails and toenails					
Shaving					
Brushing teeth					
Toileting					
Dressing or undressing					
Feeding					

Medications: Please list all current medications (prescription, over-the-counter and herbal).

Drug	Dosage	Frequency	Drug	Dosage	Frequency

ASSETS:	**RESIDENT**
Cash	$_____
Checking	$_____
Savings	$_____
Money-Market	$_____
Certificate of Deposit (CD)	$_____
Securities (Stock /Bonds)	$_____
Trusts	$_____
Annuities	$_____
IRA's	$_____
MONTHLY INCOME:	
Social Security	$_____
Pension/Annuities	$_____
IRA's	$_____
Interest/Dividend Income	$_____
Rental Income	$_____
Trust	$_____
Investments	$_____
REAL ESTATE:	
Property Address:	_____
(Name on Deed/Title)	_____
Property Address:	_____
(Name on Deed/Title)	_____
OTHER ASSETS:	
Cash Value Life Insurance	_____
Vested Pension Benefits	_____
Business Interests	_____
Automobiles	_____
Other Assets	_____
LIABILITIES:	
Home Mortgage	$_____
Credit Cards	$_____
Loans	$_____
Taxes Owed	$_____
Other Debts	$_____

PLEASE SIGN BELOW:

I hereby warrant and represent that the financial information provided above is accurate and complete. I understand that Valley Hi will rely upon it in making an admission decision. The assets listed are in fact available to the Resident to pay for the Resident's care.

_____ _____

Resident's or Responsible Party's Signature Date

Valley Hi
Nursing & Rehabilitation

PHYSICIAN LIST

Gilbert Egekeze, M.D., MBA
Oaklund Medical Group
12173 Regency Parkway
Huntley, IL 60142
847-515-2200
Centegra Woodstock Hospital
Centegra McHenry Hospital
Sherman Hospital
Provena Saint Joseph Hospital

Michael Lesser, M.D.
1095 Pingree Road, Suite 108
Crystal Lake, IL 60014
815-459-6655
Centegra Woodstock Hospital

Marcel Hoffman, M.D.
3707 Doty Road, Suite C & D
Woodstock, IL 60098
815-206-2800
Centegra Woodstock Hospital
Centegra McHenry Hospital

Ifzal Bangash, M.D.S.C.
2507 N. Richmond Road
McHenry, IL 60051
815-344-2300
Centegra Woodstock Hospital
Centegra McHenry Hospital

John O'Connell, D.O.
1835 Rohlwing Road, Suite A
Rolling Meadows, IL 60008
847-508-7514
Centegra McHenry Hospital
St. Alexius Medical Center
Advocate Good Shepherd Hospital
Northwest Community Hospital

Tanveer Ahmad, M.D.
21807 W. Grant Highway
Marengo, IL 60152
815-568-1074
Centegra Woodstock Hospital
Centegra McHenry Hospital
Belvidere Highland Hospital

Valley Hi
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PRIVATE PAY RATES
EFFECTIVE 06-01-2020

SKILLED 1 CARE (SEMI-PRIVATE)	**$295.00 PER DAY**
SKILLED II CARE (SEMI-PRIVATE)	**$305.00 PER DAY**
SKILLED III CARE (SEMI-PRIVATE)	**$315.00 PER DAY**
PRIVATE SUITE OPTION	**ADD $200.00 PER DAY**

MEDICARE CO-INSURANCE: $176.00 PER DAY (EFFECTIVE 01-01-2020)

MEDICARE CO-INSURANCE RATES APPLY ON THE 21ST THRU THE 100TH DAY.

SKILLED I, SKILLED II, AND SKILLED III RATES ARE ALL INCLUSIVE WITH THE EXCEPTION OF: MEDICATIONS, PHYSICIAN/DENTAL SERVICES, PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPY, TRANSPORTATION, BEAUTY/BARBER SHOP SERVICES, DIAGNOSTIC LABORATORY CHARGES, SPECIAL EQUIPMENT WHICH MUST BE RENTED, AND PERSONAL EXPENDITURES SUCH AS; CLOTHING, ENTERTAINMENT, ETC.

WHEN A RESIDENT IS HOSPITALIZED OR GOES HOME (for a period longer than 24 hours), THERE IS A CHARGE FOR HOLDING THE BED. THE BED HOLD RATE IS 75% OF THE DAILY RATE FOR EACH RESIDENT'S LEVEL OF CARE. THIS CHARGE IS AUTOMATIC UNLESS VALLEY HI IS ADVISED THAT THE FAMILY DOES NOT WISH TO HAVE THE BED HELD FOR THE RESIDENT.

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PLEASE BRING THE FOLLOWING, IF APPLICABLE, TO COMLETE ADMISSION PAPERWORK:

MEDICARE CARD
SOCIAL SECURITY CARD
SUPPLEMENTAL INSURANCE CARD
RX/PHARMACY CARD
POWER OF ATTORNEY PAPERS
LIVING WILL
DNR
HFS MEDIPLAN (MEDICAID) CARD
GUARDIANSHIP PAPERS

IF NOT ADMITTING FROM A HOSPITAL, A HISTORY AND PHYSICAL MUST BE DONE WITHIN 5 DAYS PRIOR TO ADMISSION.

$2000.00 DEPOSIT TO BE APPLIED TOWARD FIRST MONTH'S BILL
$30.00-$100.00 TO OPEN RESIDENT PERSONAL FUND ACCOUNT

Valley Hi
Nursing & Rehabilitation

AUTHORIZATION for RELEASE of INFORMATION

I, _____ _____
(Patient/Resident Name) (Patient/Resident Birth date)

OR

I, _____ for _____
(The Responsible Party) (Patient/Resident Name)

Authorize _____
(Name of facility from whom information is requested)

to release the following information from my medical records:

_____ MAR

_____ MEDS

_____ History & Physical

_____ Last Date of Flu & Pneumonia Vaccine

_____ Last Date & Results of TB/Mantoux Vaccine

_____ Lab Reports

_____ Therapy Notes

_____ Physician Orders

OTHER: _____

To be sent to: **VALLEY HI NURSING & REHABILITATION**
(Name of Facility)

2406 HARTLAND RD. WOODSTOCK IL 60098 **815-338-0458**
(Address of facility) (Fax number)

For the limited purpose of: _____Evaluation & Treatment_____

Information released is not to be further disclosed or used for any purpose other than that stated in this authorization. It is understood that I have the right to revoke this consent in writing at any time. Any revocation shall be in writing, signed by me and the signature witnessed by a person who can attest to my identity. No written revocation of consent shall be effective until it is received by the person otherwise authorized to disclose records and shall have no effect on disclosures made prior thereto. I understand that I have the right to inspect and copy the information released. I further understand that my refusal to consent to the release of information specified will prevent disclosure of such information to the facility or person named herein for the stated purpose.

This authorization is valid until: _____
(2 years from today's date)

_____ Date: _____
(Patient/Resident or Responsible Party Signature)

_____ Date: _____
(Witness' signature & Relationship to Patient)